



**PT and OT Authorization Request Form**  
**Please fax with supporting medical documentation**  
**800-215-4901**



Effective January 3, 2005, all Prior Authorization requests must either be faxed on this template or be submitted through the Medical Authorization Entry screen on the Web Bill Processing Portal (<http://owcp.dol.acs-inc.com>). **All required fields must be complete. Incomplete requests and requests that are not properly coded with CPT or HCPCS cannot be processed and will be returned.**

Date Requested \_\_\_\_\_ Requested by \_\_\_\_\_

Case file # \_\_\_\_\_

Claimant Name \_\_\_\_\_

Claimant Date of Birth \_\_\_\_\_

Provider Name \_\_\_\_\_

ACS Provider Number \_\_\_\_\_

Provider Tax ID \_\_\_\_\_

Date(s) of Service Requested \_\_\_\_\_

ICD-9 Diagnosis Code \_\_\_\_\_

Procedure Code(s) and/or Modifier(s) (CPT, HCPCS) \_\_\_\_\_

Specific body part to be treated \_\_\_\_\_

Right\_\_\_\_ , Left\_\_\_\_ , Bilateral\_\_\_\_ , N/A\_\_\_\_

Frequency and Duration Requested \_\_\_\_\_

Treatment Plan (include long/short term goals) \_\_\_\_\_

Comments \_\_\_\_\_

**Please remember to send prescription from attending physician and/or any supporting medical documentation for request. Please put Case File # on every page faxed.**